Si desea ayuda en español, llame al 1-800-321-0291. Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.
한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오. Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

Health Coverage Tax Credit (HCTC)-Basic Health Application

Basic Health™

Use blue or black ink to complete this application.
Giving us your social security number is voluntary.

Questions about HCTC? Call the HCTC Customer Contact Center at 1-866-628-4282.
Questions about this application? Call 1-800-660-9840 and say you're interested in HCTC-Basic Health.

APPLICANT AND HOUSEHOLD INFORMATION

If you need help in a language other than English, what language and dialect do you speak?_____

Applicant's last name	First name	Middle initial

Street address Apt. #	City	State	ZIP Code
Mailing address or PO box, if different from above	City	State	ZIP Code

Home phone number ( )	Other phone number ( )	Marital status (check one): ❑ Single ❑ Separated ❑ Legally married
E-mail address		Do you have access to the internet? ❑ Yes ❑ No

FAMILY MEMBERS (If you need more space, please use a separate sheet or copy this page.)

Complete this section for all family members even if not requesting coverage.			Gender	Requesting coverage?
For applicant listed above →	Social security number	Birth date	❑ M ❑ F	❑ Yes ❑ No
Spouse's last name, first name, middle initial	Social security number	Birth date	❑ M ❑ F	❑ Yes ❑ No

1	Last name, first name, middle initial		Social security number	
	Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Birth date	Gender ❑ M ❑ F	Requesting coverage? ❑ Yes ❑ No
2	Last name, first name, middle initial		Social security number	
	Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Birth date	Gender ❑ M ❑ F	Requesting coverage? ❑ Yes ❑ No
3	Last name, first name, middle initial		Social security number	
	Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Birth date	Gender ❑ M ❑ F	Requesting coverage? ❑ Yes ❑ No
4	Last name, first name, middle initial		Social security number	
	Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Birth date	Gender ❑ M ❑ F	Requesting coverage? ❑ Yes ❑ No

Basic Health contracts with private health plans in Washington State.
You must choose a health plan in the section below.

HEALTH PLAN SELECTION

Choose one health plan for your family. Not all health plans are available in every county. Read *Understanding HCTC-Basic Health* to see the plans available where you live. If you live outside of Washington, you must choose a county where you will receive your HCTC-Basic Health services, and then you must choose a health plan available in that county.

Washington State county where you live, or, if you're not a Washington State resident, the Washington State county where you will receive services:_____

Choose your health plan:

- ❑ Columbia United Providers, Inc.
- ❑ Community Health Plan of Washington
- ❑ Group Health Cooperative
- ❑ Molina Healthcare of Washington, Inc.

AGREEMENT AND SIGNATURE

I understand that: I must report address changes, changes in my HCTC eligibility, and changes in my family (for example, a marriage or divorce, the birth of a child, or a child who leaves the home or is no longer a dependent).

I authorize any health plan or medical provider to give medical records for me or my children to Basic Health, for purposes of participation in Basic Health. I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application and attachments is true, correct, and complete to the best of my knowledge. I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under Basic Health, and may face other penalties, prosecution, and collection.

AGREEMENT MUST BE SIGNED BY YOU AND YOUR SPOUSE, AND DEPENDENTS AGE 18 AND OVER WHO ARE ASKING FOR COVERAGE

X _____ Signature of applicant	_____ Date	X _____ Signature of spouse	_____ Date
X _____ Signature	_____ Date	X _____ Signature	_____ Date
X _____ Signature	_____ Date	X _____ Signature	_____ Date

IS YOUR APPLICATION COMPLETE?

Use this checklist below to make sure you include:

- ❑ Application signed by subscriber and spouse, and any family members over age 18 who are requesting coverage.
- ❑ Your health plan choice and county of service at the top of the second page of this application.
- ❑ A copy of your "candidate letter" from the Internal Revenue Service/Health Coverage Tax Credit program.

Please enclose the required forms and documentation, and either fax to (360) 923-2605 (please call us first at 1-800-660-9840 to let us know your fax is coming), or mail it to Basic Health, PO Box 42703, Olympia, WA 98504-2703.
Questions? Call 1-800-660-9840. On the Internet, go to www.basichealth.hca.wa.gov.

Privacy statement: Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling (360) 923-2822 or online at www.hca.wa.gov.